

8336

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH a. COUNTY <u>Howard Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Horsley Rd.</u>		d. STREET ADDRESS <u>Horsley Road</u>	
3. NAME OF DECEASED (Type or print) <u>LODEMA BALLANTINE</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Barnett</u>		14. MOTHER'S MAIDEN NAME <u>Crowell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Wm. A. Ballantine</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>583X Congestive heart failure</u> DUE TO (b) <u>Uremia & jaundice</u> DUE TO (c) <u>Hepatic discharge & peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		20g. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8/20/56</u> , 19____, to <u>8/24/56</u> , 19____, that I last saw the deceased alive on <u>8/24/56</u> , 19____, and that death occurred at <u>7:12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James N. Linder</u> M.D.		ADDRESS (Street, city or town, state) <u>1305 Lander Ave</u> DATE SIGNED <u>8/24/56</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	22d. LOCATION (City, town, or county) <u>Howard Co Md</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macnab & Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>8/28/56</u>	24b. REGISTRAR'S SIGNATURE <u>C. Rud Williams</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 4

AUG 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08363

8387

CERTIFICATE OF DEATH

Reg. Dist. No.

195

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>SAME</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAVAGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>70 Washington St.</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Alfred Beaty</u>		4. DATE OF DEATH Month Day Year <u>AUG 21 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucas</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 22, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COTTON FACTORY</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARION BEATY</u>		14. MOTHER'S MAIDEN NAME <u>SALLY FIGGINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-09-7482</u>	
17. INFORMANT <u>LEON BEATY</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1956</u> to <u>Aug 21 1956</u> , that I last saw the deceased alive on <u>Aug 21 1956</u> , and that death occurred at <u>130 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Buell M.D.</u>		ADDRESS (Street, city or town, State) <u>402 Main St. Laurel Maryland</u>	
PHYSICIAN'S NAME (Type) <u>John R. BUELL</u>		DATE SIGNED <u>8/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug 23-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SAVAGE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SAVAGE-HOWARD-MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. (Ronaldson) Quirk M.D.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Frank Shipley</u>	
DATE <u>8/23/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

AUG 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08364	
Item 18 Film G204 9-24-55										197	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Howard MARYLAND					2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Md b. COUNTY Howard						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 144					d. STREET ADDRESS Rt. 144					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNON Middle EDWARD Last BLAIR					4. DATE OF DEATH Month August Day 28 , Year 1956						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1926		9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk					10b. KIND OF BUSINESS OR INDUSTRY Int. Harvester		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edward L. Blair					14. MOTHER'S MAIDEN NAME Georgia E. Blucher						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. II					16. SOCIAL SECURITY NO. 216-22-8549		17. INFORMANT Mrs. Mary Jane Blair, Address Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Functional heart disease 433.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 9/28/56	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 8-31-1956		22c. NAME OF CEMETERY OR CREMATORY Taylorstown			22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland					24a. REC'D BY REGISTRAR 9/30/1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick				

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A. E.

AUG 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8389

CERTIFICATE OF DEATH

Reg. Dist. No.

08365
190

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u>				c. LENGTH OF STAY IN 1b <u>5-7-10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Elkridge, Rural</u>			
3. NAME OF DECEASED (Type or print) <u>ETHEL- P - DUBBS</u>				4. DATE OF DEATH <u>Aug 18 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 7 - 1870</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William A. Powell</u>				14. MOTHER'S MAIDEN NAME <u>Sallie M Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mrs Geo F Somerville, Elkridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>± Hemiplegia</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1951</u> , 19 <u>56</u> , to <u>Aug. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 9</u> , 19 <u>56</u> , and that death occurred at <u>3 2</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B.B. Brumbaugh</u>		M.D. <u>Elkridge - 27 Md.</u>		DATE SIGNED <u>8/10/56</u>			
PHYSICIAN'S NAME (Type) <u>B.B. Brumbaugh M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton</u>		ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Aug 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>E. Bird Williams</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
CERTIFICATE OF DEATH

BUREAU V. S.

AUG 14 1956

RECEIVED

8390

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Highland Manor Home</u>				d. STREET ADDRESS <u>7118 Rodgers Court</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel A GARMER</u>				4. DATE OF DEATH Month Day Year <u>Aug. 14 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1867</u>		9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cigar maker-retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Frederick C. Garmer</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca L. Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Wm. M. Garmer 7118 Rodgers Court</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hemipia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>new yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/12</u> ; 19 <u>56</u> , to <u>8/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Max J. Miller M.D.</u> <u>5226 Baltimore & Pk</u> <u>8/15</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc. 1217 St Paul St.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughren</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 18

FILE NO.

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Tobacco Used

Other Habits

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Anthropologist

Signature of Dentist

Signature of Nurse

BUREAU V. S.

AUG 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08369

8391

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1 PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS 12 Falls Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3 NAME OF DECEASED (Type or print) GEORGIA JOHNSON		First		Middle		Last		4. DATE OF DEATH Aug. 2, 1956		Month		Day		Year 19													
5 SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-1895		9 AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Samuel Scott		14. MOTHER'S MAIDEN NAME Carrie Ward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO ?													
17. INFORMANT Wm. Johnson, Ellicott City, Md		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANEURYSM, RUPTURED DUE TO (b) ATHEROSCLEROSIS DUE TO (c) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)							
21. I certify that I attended the deceased from FEB. , 19 56 to AUGUST , 19 56 , that I last saw the deceased alive on AUGUST 1 , 19 56 , and that death occurred at 2³⁰ A.M. , from the causes and on the date stated above.		ACTUAL SIGNATURE Donald E. Fisher		M.D. ELLICOTT CITY MD		DATE SIGNED 8-2-56		PHYSICIAN'S NAME (Type) Donald E. Fisher		Ellicott City, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-1956		22c. NAME OF CEMETERY OR CREMATORY Western Star		22d. LOCATION (City, town, or county) (State) Catonville, Md		23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE J. E. Loughran	

AND V. S.

or 1 / 2

THE AMERICAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8392

CERTIFICATE OF DEATH

08370

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>A</u> Last <u>Richardson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1956</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>International Harvester</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph V. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Alice M. Bayne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-0528</u>		17. INFORMANT <u>Mrs. Marian E. Richardson</u>		Address <u>1309 E. Belvedere Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis due to cerebral arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>August 5, 1956</u> , to <u>August 17, 1956</u> , that I last saw the deceased alive on <u>Aug 17, 1956</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving J. Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Taylor Manor Hospital</u>		DATE SIGNED <u>8/17/56</u>	
PHYSICIAN'S NAME (Type) <u>Irving J. Taylor, M.D.</u>				<u>Ellicott City, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ridge (St. Mary's Co.) Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Cook, Inc.</u>				ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. E. Laughren</u>			

BUREAU V. S.

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8393

CERTIFICATE OF DEATH

08371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville RFD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R F D			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HATTIE SUITS				4. DATE OF DEATH Month Aug. Day 14 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 6, 1879	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew Franklin Collehon				14. MOTHER'S MAIDEN NAME Virginia Castle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N ne		17. INFORMANT George W. Suits, Brookville, Md Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. arteriosclerotic heart disease DUE TO (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, left lung 30 years						INTERVAL BETWEEN ONSET AND DEATH 5 days 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/23, 1946 , to 8/14, 1956 , that I last saw the deceased alive on 8/14, 1956 , and that death occurred at 12:00 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker		M.D. CLARKSVILLE		DATE SIGNED 8/16/56			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, A. O.		MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-56		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Highland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE 8-16-56		24b. REGISTRAR'S SIGNATURE Marie A. Whitaker	

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.

BUREAU Y. B.

AUG 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 191

8394

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 60yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle KIRN Last THOMPSON		4. DATE OF DEATH Month August Day 21 Year 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25 1880
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Kirn		14. MOTHER'S MAIDEN NAME Mary Bassler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William F. Thompson		Address Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hypertension DUE TO (c) Carcinoma of sigmoid metastases		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to 21 Aug , 19 56 , that I last saw the deceased alive on 21 Aug , 19 56 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William J. Bryson M.D.		ADDRESS (Street, city or town, state) 4605 Edmondson Ave., Balto. DATE SIGNED 23 Aug 56	
PHYSICIAN'S NAME (Type) WILLIAM J. BRYSON		4605 Edmondson Ave., Balto., Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-24-1956	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City, Md.	
24a. REC'D BY REGISTRAR Aug. 23, 56		24b. REGISTRAR'S SIGNATURE John B. Loughran, Jr.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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